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FROM THE EDITOR, THE OFFICE OF HEALTH POLICY NEWSLETTER

THE REAL INFORMATION TECHNOLOGY CHALLENGE

Earlier this year, I had the privilege of speaking at national meetings sponsored by the SMS Corporation (Malvern, Pennsylvania) and the Eclipsys Corporation (Delray Beach, Florida). Knowledgeable readers would agree that these two firms represent some of the elite health information technology (IT) companies in the United States.

Personally, my information technology skill set is modest, so to prepare for these presentations, I began several months of industry interviews and voracious reading of trade journals and computer oriented textbooks. For example, I scoured magazines like *Healthcare Informatics* and articles like "Nine Hot Technology Trends."¹ Ergo, I became familiar with terms like bandwidth, traffic congestion, and back-end database. I was enamored of the potential power of the data warehouse and the seemingly ubiquitous reach of powerful, nationally prominent chief information officers, or CIOs. I even co-authored an essay in one of these magazines to test the waters and demonstrate some fluency with their arcane language.²

Yet, my preparation left me with a nagging unease about the real role of IT in health care. Several intertwined events made me re-think the role of IT. Let me share these events with you, the reader, and offer some sobering insight as to the future of IT in health care.

Accomplishments in IT have been synonymous with Intermountain Health Care, a health system of 23 hospitals and medical centers headquartered in Salt Lake City, Utah. For nearly 15 years,³ IHC has been an acknowledged leader in the creation of the computerized patient record, and the so-called Health Evaluation Through Logical Processing (HELP) system. For all of their technical prowess, what I have learned about IHC is through the work of one of their leading physician researchers, and my close friend, Dr. Brent James. Brent's message about IT is deceptively simple; he preaches a message that says "You manage what you measure." Central to being able to measure and therefore manage is clinical integration, which has been discussed in these pages previously (see January 1998 *Health Policy Newsletter*, Editorial). According to Brent's definition, clinical integration means a shift from a financial measurement model to a clinical process model which closely mirrors the core way we actually accomplish our work as clinicians. In a nutshell, Brent got me thinking about the real mission inherent in all of the technospeak that often muddies the conversational waters when it comes to IT.

Last spring, on the very day that the stock market eclipsed the 10,000 mark, the *Wall Street Journal*⁴ ran a front page story entitled, "The Rocket Under the Tech Boom: Big Spending by Basic Industries," written by reporters with a strong health care pedigree such as George Anders and others. Anders points out that when adjusted for price fluctuations, IT outlays now account for more than one-quarter of all U.S. investment and more than half of business spending on new machines. The article goes on to celebrate the continued payoff from information technology and what it has done for some of the 30 companies that

comprise the Dow Jones Industrial Average. In short, the message was "the more technology, more profits, the higher the stock market." This, of course, reinforces a popularly held belief in the power of technology both in and out of the health care sector.

Finally, a colleague shared with me a recent article in the *Harvard Business Review*⁵ that crystallized my thinking. While astute observers recognize that in 1997, the health IT industry, taken as a whole, represented \$15 billion worth of good and services and by the year 2000, the best estimates put it at \$25 billion worth of goods and services. This reflects what market watchers know is a price-earnings ratio for the industry of greater than 33, eclipsing the Standard and Poors' price earnings ratio of 23. Yet, those *Harvard Business Review*⁵ authors contend we've missed the main point. In their study, evaluating how Japanese and Western managers frame IT management questions, they discovered some startling concepts.

Western corporations frame IT using five management principles: strategic alignment, value for money, technology solutions, user relations, and systems design. This business school jargon really means that in a Western context we ask: What is the return on our capital investment for technology? We develop an IT strategy that aligns with our business strategy, and we adapt capital budgeting processes to manage and evaluate these types of IT investments. The authors go on to conclude that we assume that technology offers the smartest, cheapest way to improve performance, and we design the most technically elegant system possible and ask our employees to adapt to it. Does this sound like *your* integrated delivery system, *your* managed care company, or *your* practice?

On the other hand, the Japanese firms studied framed the IT management question with the concepts of strategic instinct, performance improvement, appropriate technology, organizational bonding, and human design. These concepts, loosely translated, mean we let the basic way we compete, especially our operational goals, drive the IT investment. We judge investments based on operational performance improvement and not necessarily a detailed return on investment calculation. The Japanese do not establish the office of the Chief Information Officer. Alternatively, they encourage integration by rotating managers through the IT function, co-locating specialists and users and giving IT oversight to executives who also oversee other functions. Instead of system design, their human design recognizes the use of the tacit and explicit knowledge that employees already possess. To me this sounds like Brent James again: "You manage what you measure."

Put in another way, the real challenge of IT in health care means we must begin to answer the question, What do we want to improve and by how much, and is it the length of stay, the cost per case, the infection rate, adverse drug reactions, or all the above? We need to pick our IT battles more selectively and focus with laser-like precision on opportunities to improve performance. This strategy will lead to improvements in quality and lower costs in the long run. My message to SMS and Eclipsys was to ask the right questions and to help their customers to reflect on these Western and Eastern approaches to the power of IT in health care.

What about the future? Shaller and others, writing in *JAMA*,⁶ have called for a national action plan to meet the health care quality information needs in the age of managed care. They propose a coordinated national network of independent public-private quality measurement alliances established through strong purchaser and consumer leadership at the state, regional, or local levels. They further argue that these independent alliances would each undertake specific quality measurement and consumer information projects to meet local health care market needs by drawing on combinations of the emerging national standardized quality measures. Regrettably, I believe this is unworkable in our heterogeneous health care economy that worships decentralization.

Fortunately, the leadership of American medical education, is, I believe, up to the challenge. Witness the recent report from the Medical Schools Objectives Project (MSOP) of the Association of American Medical Colleges, specifically, their second report⁷ from the Medical Informatics Panel. This panel (a blue-ribbon collection of experts from around the country) identified five physician roles in which informatics plays a vital part: life-long learner, clinician, educator-communicator, researcher, and manager. The panel defines strict criteria and informatics learning objectives important for each role. In my view, they have gone a long way toward delineating the real role of IT in health care for the future. I hope that many of our colleagues in medical education throughout the Jefferson Health System and across the country take these recommendations to heart and begin the difficult process of operationalizing them.

We can only "manage what you measure" so we must be very careful about what it is we select to manage. Pick those areas that will improve performance and recognize that the return on the capital investment will come later. As usual, I am very interested in your views.

- David B. Nash, MD, MBA

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THE JEFFERSON MEDICAL COLLEGE SUMMER RESEARCH PROGRAM

BY HANNA ZAFAR, JMC, CLASS OF '02
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For over 100 years Academic Medical Centers (AMCs) and biomedical research have enjoyed a synergistic partnership, summarized by the observation that "medical science instruction becomes history instruction in the absence of biomedical research."¹ However, recent legislative and market changes, combined with decreasing numbers of medical students and physicians entering research,² are challenging the structure of this partnership. In an effort to maintain the research arm of academic medicine's tri-partite mission during this restructuring, Jefferson Medical College (JMC) has implemented a joint federal-medical school interdisciplinary Summer Research Program linking students with a broad cross section of university researchers in such fields as orthopedics, medical informatics, ob/gyn, oncology, neurosurgery and health policy.

The primary goal of the Summer Research Program is to further students' understanding of translating research methodology to problems of patient care. By the end of their summer program, students are required to formulate testable hypotheses in their area of immersion. The program pairs qualified students with established mentors to expose them to

the critical thought process and analytic techniques involved in planning, executing and presenting research. This approach, while traditional, is based on the fact that a physician's decision to enter research is made more often during medical school than at any other time.³ The program also strives to identify and recruit under-represented undergraduate minorities. The Cancer-Related Basic Research program, in its outreach efforts, encourages individuals to consider careers in biomedical research. Despite the fact that Blacks, Native Americans, Mexican-Americans and mainland Puerto Ricans comprise 20% of the population, they account for only 6% of US physicians.⁴ Such statistics have compelled the American Association of Medical Colleges (AAMC) to strongly promote entrance of minorities and underrepresented groups into medical schools through policies and advocating programs similar to JMC's Summer Research Program.

The Summer Research Program was originally supported by an NIH short-term training grant for medical students from 1980-1988. After eight successful years and 107 published abstracts and papers, Dr. Joseph Gonella, Dean of JMC, initiated the General and Computer Research programs in 1989 to continue the benefits of such training. The following year, in 1990, Dr. George Alexander, director of undergraduate medication education, Department of Radiation Therapy and Nuclear Medicine, received funding from the National Cancer Institute to found a Cancer-Related Basic Research program which, in addition to existing medical students, also included pre-matriculated medical students and under-represented undergraduate minority students. Finally, in 1996 and 1998, under the coordination of Ken Chepenik of Thomas Jefferson University's Office of Scientific Affairs, and under the direction of Dr. Scott Waldman of the Department of Medicine and Clinical Pharmacology and Dr. Allen Lefer of the Department of Physiology, the National Heart, Lung, and Blood program and the Translational Cancer Research program were funded. Support for these programs was obtained from the National Heart, Lung, and Blood Institute and the NCI, respectively.

This year, 100 applicants from among existing medical students, pre-matriculating medical students, and minority undergraduate students competed for the 36 supported summer research positions awarded across all five divisions. Upon acceptance to the program, students are matched with a preceptor and encouraged to meet before the summer to review pertinent literature and discuss project objectives, design and implementation. Working under an intense 10-week timeframe, participants meet frequently with preceptors in order to review progress and discuss findings. At the end of the summer, students are required to make an oral presentation to other program participants and submit a scientific abstract of their work. In addition to receiving a stipend, participants are eligible for a \$1,000 tuition rebate contingent upon submitting their project work in the form of a scientific publication to the JMC Selection and Education Committee.

Since the inception of the current program in 1989, summer student researchers have published and presented 76 abstracts and papers in established journals and national association conventions across the country. Several program participants have even transferred from the MD to the MD/PhD program, citing their summer research experience as impetus for such a move. Regarding the undergraduate minority participants, 10 of the past 20 participants have pursued higher education in the sciences, and three students with bachelor degrees are working as research technicians and plan to apply for MD, MD/PhD and DVM programs.

Only time will reveal how recent changes including the Balanced Budget Act of 1997⁵ and managed care⁶ will ultimately effect the ability of AMCs to promote their mission of education, patient care and research. Present limits on federal reimbursement for AMC administrative costs, salaries, awards and graduate student tuition have shifted costs to medical schools at a time when funding from clinical revenue, which historically covered these costs, has been decreasing.⁷ To add to this burden, despite 1999 Congressional budget approval for the largest increase in NIH funding, declining numbers of first-time MD applicants for NIH research grants will trend out to zero by 2003.² In other words, research is threatened by both external and internal forces: the external force of cost restructuring, and by the internal force of low interest in research within the physician pool. In this milieu, JMC's Summer Research Program illustrates a means to foster renewed interest in the physician-scientist through strengthening the University's research arm as well as the quality of its medical education.

For further information on the JMC Summer Research Program, contact Dr. Catherine Calkins, Department of Microbiology and Immunology, 215-503-7950, or contact individual program directors as follows: Cancer-related Basic Research: Drs. Mahroo Haghbin and Ronald Coss; Translational Cancer Research: Drs. Scott Waldman and Laurence Eisenlohr; National Heart, Lung, and Blood Research: Dr. Allan Lefer; General Medical Research, administered through the Office of Scientific Affairs: Dr. Catherine Calkins; and the Computer Program, administered through the Office of Academic Computing: Dr. Rod Murray.

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CARDIOVASCULAR DISEASE AND HEALTH CARE DILEMMAS IN THE PHILADELPHIA VIETNAMESE COMMUNITY

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Studies on the health of Vietnamese immigrants have shown low self-awareness of cardiovascular illness and low health care utilization.¹⁻⁴ To assess awareness and understanding of cardiovascular diseases, health care barriers, and cultural beliefs in the Philadelphia Vietnamese community, the Department of Family Medicine conducted a qualitative research study during the summers of 1996 and 1997. Our findings suggest that specific, community-based, health care services are needed and can be implemented to enhance education and the community's access to health care.

Information was collected from focus groups, family interviews, and individual interviews of community members (n=61) and health care providers (n=5). Community interviews were conducted in Vietnamese, transcribed, and translated. Provider interviews were conducted in English.

The study results identified that awareness is higher than expected for hypertension but is low for heart disease. Moreover, individuals' understanding of the etiologies and prevention of cardiovascular disease is low, as is their health care utilization. The major barriers to use of health care include

problems with language, medical insurance, and transportation. Community members surveyed desire resources such as interpreter services, increased medical insurance, translated educational materials, health education classes, and community health fairs. Importantly, the majority believe that Western medicine is necessary for care and is “stronger, faster, and more curative” than Eastern folk medicine, which is seen as “weaker, slower, and preventive.” Folk medicine is used primarily for routine maladies such as colds and headaches; there was little or no application of folk medicine for hypertension or cardiovascular disease.

This study allows for better insights into care for chronic illnesses such as hypertension and cardiovascular disease in the Vietnamese community and for better approaches to the perceived health care barriers. Prior discussions of care for this population have been directed toward health care providers and are mostly concerned with the understanding of the cultural beliefs and behaviors of the patient. As the community's acceptance of the role of Western medicine is high, strategies to improve the health status of Vietnamese immigrants should include working directly with the community for such services.

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This study has been accepted for publication in Family Medicine. The Department acknowledges the support of the Edna G. Kynett Memorial Foundation under a grant for education of primary care physicians in cardiovascular disease, and the assistance of the Health Promotion Council of Southeastern Pennsylvania.

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JEFFERSON GRADUATE CERTIFICATE PROGRAMS FOR CAREER ADVANCEMENT

GEORGANNE K. BUESCHER, EdD
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THOMAS JEFFERSON UNIVERSITY

The Graduate Center for Education and Training of the College of Graduate Studies is pleased to announce new training opportunities that provide professionals in industry and academia with the skills and knowledge needed to be successful in today's changing environment.

Health-related industries are projected to continue their steady growth for years to come. There is considerable demand for qualified professionals. In response, the College of Graduate Studies, a leader in planning and implementing high quality graduate programs, has developed certificate programs to be offered at times convenient to practicing professionals and focused on growth areas in healthcare industries. These programs are offered through the Graduate Center for Education and Training.

The certificate programs (15 credit hours of graduate course work in specific fields) aim to improve technical and managerial skills in preparation for career advancement or to gain knowledge and skills in new areas for increased career options, without interrupting employment. Programs of study are available in the following fields:

- Clinical Research/Trials
- Public Health/Health Systems Research
- Research Administration

The certificate programs comprise about one-third of the requirements for a Master of Science degree. The programs incorporate courses selected from our existing programs in the College of Graduate Studies: 1) Master of Science in Developmental Biology and Teratology, 2) Master of Science in Biomedical Chemistry, 3) Master of Science in Microbiology, and 4) Master of Science in Pharmacology. As there are fewer course requirements for certificate programs than for formal degree programs, degree candidates and fellows may also pursue certificates as part of their graduate curriculum. Courses within certificate programs must be taken for academic credit and may be applied to appropriate existing professional Master of Science programs.

For each of the three certificate programs, students are required to take four (4) core courses, and a total of five (5) credits of electives (e.g., two or three courses). Sample core courses are: Fundamentals of Clinical Trial Management, GC 635 (for the Certificate in Clinical Research); and Pharmacoeconomics/Health Policy, GC 650 (see September 1997 *Health Policy Newsletter*, "The College of Graduate Studies Offers New Course") for the Certificate Program in Public Health. Sample elective courses for the Certificate in Research Management include: Grants Management, GC 615; and Biotechnology in Venture Management, GC 621.

Graduate course work in the above areas of concentration is offered through afternoon and evening courses. These programs make completing or enhancing a degree or getting new skill sets accessible and affordable. Certain courses will also be available through our distance learning program later this year. Qualified candidates for certificate programs include:

- Graduates of baccalaureate programs in basic sciences, nursing, health professions, engineering, or business
- Graduates and students in professional programs (medicine, dentistry, veterinary medicine, law)
- Graduates and students in doctoral/post-doctoral programs

The application process for graduate certificate programs is simple. Applicants must submit the application form with a \$40.00 non-refundable application fee and the following documents: an official college transcript demonstrating completion of a baccalaureate, graduate or professional degree and a letter of recommendation from an employer, supervisor, or academic faculty member. Graduate Record Examination (GRE) scores are recommended, but not required for the Certificate Programs. Applicants from non-English speaking countries must submit the results of the Test of English as a Foreign Language (TOEFL). A minimum TOEFL score of 550 is required for admission to certificate programs. Courses completed for a certificate program may later be applied toward a graduate degree program.

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<http://jeffline.tju.edu/CWIS/CGS>

For more information, e-mail to: grad-cert@mail.tju.edu or call Eleanor Gorman at 215-955-5799.

THE JEFFERSON HEALTH CARE COLLEGE

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One of the principle challenges facing an integrated health care delivery system is how to improve quality by reducing variability in care. The Jefferson Health Care College (JHCC), created in 1998, (see May 1997 *Health Policy Newsletter*, "The Jefferson Health System Primary Care College: A New Beginning") is a continuing medical education (CME) vehicle with the goal of impacting physician behavior to improve quality of care.

Co-directed by the author and Geno Merli, MD, FACP, Ludwig A. King Professor and Director, Division of Internal Medicine, and Vice Chairman for Primary Care, Department of Medicine, the JHCC completed its first semester of courses in June, 1999. Over 350 hospitals attended one or more of the courses offered from January through June 1999: Hospital Medicine; Primary Care Approach to Colorectal Diseases; Primary Care Approach to Office Gynecology; Dermatology; Disease State Management; Asthma; Congestive Heart Failure; Diabetes; and the week-long Eastern Shore Medical Symposium in Rehoboth Beach, Delaware.

Several key concepts underlie the development of the JHCC. Unlike the development of many CME courses, the JHCC courses are chosen by a steering committee. These selections are based on an assessment of managed care data, as well as traditional needs assessment. All courses are planned by a collaborative team of primary care and specialist physicians. Emphasis is given to development of specific skills that improve efficiency and quality of care. Accordingly, virtually all the courses include interactive case discussions and skills workshops in such areas as flexible sigmoidoscopy, skin biopsy, and patient education.

Course faculty are drawn from primary care and specialty departments with coordination by the JHCC workgroup. Tim Brigham, PhD, and Jeanne Cole, MEd, of Jefferson Medical College's Department of Continuing Medical Education, supervise course development and obtain CME accreditation. A primary care physician can meet his or her entire CME requirements by attending the JHCC.

Although evaluations of JHCC courses have been strongly favorable, assessment of their impact on practice behavior changes is premature. In order to increase the likelihood of altering physician behavior, participation in the JHCC will need to be complemented by feedback on current practice behavior and creation of incentives to reduce variability of care. Thomas Jefferson University anticipates that JHCC can be one key component of the Jefferson Health System's strategy to improve quality of care.

Notice of the 1999-2000 curriculum for the JHCC has been mailed to regional physicians. Courses include Primary Care Approach to Vascular Diseases, Dermatology, Preventive Health Care, Infectious Diseases, Management of the Symptomatic Patient, and the Eastern Shore Medical Symposium. For more information about the JHCC and course registration, call Donna Barton, 215-955-6993.

PREPARING FOR EVIDENCE-BASED PRACTICE: THE JEFFERSON HEALTH SYSTEM TOOLBOX

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Evidence-based medicine (EBM) is getting a lot of press as the newest, and truest, way to improve quality—scientifically. EBM can be viewed as the combination of the application of [knowledge of] “best evidence” with the time-honored tenets of sound medical practice, toward the systematic improvement of health care quality. In November 1998, the Jefferson Health System (JHS) Quality Council, under the direction of Chief Medical Officer, Stanton N. Smullens, MD, initiated a System-wide educational effort, “Preparing for Evidence-Based Practice: The JHS Toolbox.” This program aims to familiarize the JHS clinical leaders with the principles and tools of EBM and to facilitate the System's move toward ongoing improvement and clinical integration.

“Integrating individual clinical expertise with the best available external clinical evidence is what EBM is really all about,” says David Nash, Director and Associate Dean, Health Policy, and “why it represents such an exciting turning point in caring for our patients.” (see January 1999 *Health Policy Newsletter* Editorial.)

“Toolbox” is the first in a series of step-wise courses focused on the application of EBM. The program's objectives are: 1)

to develop an evidence-based approach to the delivery of care; 2) to link an evidence-based approach with data available within the health care system; 3) to link an evidence-based approach to delivery of health care with system-wide performance measures; 4) to identify system-wide clinical and administrative data bases for performance measurement; 5) to identify individuals with appropriate expertise for performance measurement on an institutional level; and 6) to discuss the limitations in performance measurement within an integrated health care system.

Clinical faculty facilitating the course were also among its creators: Dr. Smullens; Thomas Nasca, MD, Associate Dean and Vice Chairman, Education and Research, JHS and JMC; Jeffrey Lenow, MD, JD, Medical Director, JeffCare; and David B. Nash, MD, MBA and Robert R. Corrato, MD, Director and Deputy Director, respectively, of OHP, and Barbara Bozarth, MSed, also of OHP.

The course takes a hands-on approach, quickly advancing to the practicalities of applying newly learned tools. The first session provides an overview of the forces impacting the health care marketplace today, with an emphasis on Philadelphia and the Delaware Valley. The philosophical principles underpinning EBM are explored, and inpatient and outpatient case studies are examined as a way to build measurement into practice. Participants are then asked to compare and contrast hypothetical performance measurement projects and to share proposed strategies for presenting physician data. At the end of the first session, they are given a homework assignment to profile an aspect of their practice. The homework results are shared at the followup session. Participants are then challenged to develop their own report cards. Incorporated throughout the course are review sessions and a round table discussion focused on meeting and overcoming challenges.

“Preparing for Evidence-Based Practice: The JHS Toolbox,” continues to extend the messages of quality improvement, guidelines, and outcomes measurement to the medical and administrative staff of the members and alliance members of JHS. As an extension of the pilot program, Albert Einstein Medical Center, Frankford Health Care System, Christiana Care Physician Organization, and Bryn Mawr Hospital have requested on-site, customized mini-sessions of the concepts presented in “Toolbox I.” Based on the success of “Toolbox I,” the Quality Council is launching “Toolbox II: Benchmarking Clinical Activity,” this fall/early winter 1999.

If you are interested in scheduling “Preparing for Evidence-Based Practice: The JHS Toolbox,” or “Toolbox II: Benchmarking Clinical Activity” at your institution, please contact Barbara Bozarth at 215-955-2822.

JMC's INTERDISCIPLINARY SMOKING CESSATION PROGRAM

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RESEARCH AND TREATMENT

Tobacco smoking is the leading cause of preventable death in the United States, accounting for more than 400,000 deaths per year.¹ This is an astounding figure, equivalent to three 747 airliner crashes per day, each day for the entire year. Despite these risks, the prevalence of smoking remains quite high, with approximately 25% of the adult US population currently smoking cigarettes.² Of all of the attributable smoking related diseases, lung cancer remains one of the leading sources of major morbidity and mortality within the population, and a significant source of healthcare resource expenditure, especially among economically disadvantaged cohorts.³ Such sobering statistics belie the fact that about 70% of smokers express a desire to quit, and 50% make some attempt at cessation annually.⁴ Yet long term success remains elusive for the vast majority of smokers.

In order to significantly improve these dismal rates, a successful smoking cessation intervention may require intensive staffing resources, for example, providing patient counseling and arranging periodic follow-up visits, resources most primary care physicians, the traditional providers of cessation services, may not have at their disposal. A seeming contradiction emerges, given that treating a patient for smoking cessation is inexpensive, estimated at less than \$2,000 per quality adjusted life year (QALY) saved.⁵

Recognizing that nicotine addiction intervention can be an extremely resource intensive undertaking; and perceiving significant limitations with commercially available cessation programs, several faculty and staff from a number of departments and divisions within JMC (The Comprehensive Center for Tobacco Research and Treatment) pooled their individual expertise to create an innovative, interdisciplinary smoking cessation intervention, the Jefferson Tobacco Intervention Program (JeffTIP). JeffTIP, launched in July 1998, was designed to address several key elements that are emerging

as critical to long term cessation: patient-centered, intensive provider interaction and followup, and an interdisciplinary, "one-stop shopping" setting that facilitates optimal patient treatment and management. Based at Thomas Jefferson University Hospital (TJUH), the program offers a unique integration of medical evaluation and management with intensive individual psychological counseling, group educational seminars and combination pharmacotherapy to create a medical model of addiction treatment. Patient education and relapse prevention form the philosophical foundation of the program. JeffTIP is open to patients in the community as well as to physician-referrals. JeffTIP is designed to offer particularly intensive resources for the most severely addicted patients, those who have experienced frequent relapses and who suffer from significant co-morbidity.

JeffTIP aims to take the knowledge gleaned about cost-effective pharmacologic treatments to the next level. The research question in this context becomes how to stratify the population into type of smoker (i.e., based on motivational level, severity of addiction, psychosocial barriers to success, etc.), and developing the appropriate intervention. Multidisciplinary input becomes imperative. The Agency for Health Care Policy and Research (AHCPR) has made great strides in removing and reducing barriers to effective physician treatment of nicotine addiction through its *Smoking Cessation Clinical Practice Guideline*.⁶ A successive AHCPR document on designing effective nicotine addiction programs is forthcoming.

Patients wishing to receive treatment, or physicians wishing to refer a patient can call JeffTIP at (215) 955-STOP. Once registered, patients receive a complete evaluation. Psychologic and physiologic measurements are taken, such as severity of the nicotine dependency, readiness to quit, ability to cope with cravings, past quit attempts, etc. A quit strategy is individually tailored, including pharmacologic therapy. Patients are then invited to the JeffTIP educational seminar onsite, which runs concurrently. Patients visit TJUH weekly for the first six to eight weeks, then are followed every few months, for a year. Throughout the initial program period, patients receive periodic follow-up visits with the physician and psychologists, and receive individual counseling with a nurse practitioner.

Despite the adverse patient selection, JeffTIP has experienced an excellent completion rate (approximately 85% to date) and has received consistently excellent satisfaction ratings from its patients. Clinical outcome data suggest a 63% three-month continuous abstinence rate.

A remaining challenge for the program is that JeffTIP services remain unreimbursable for providers; no area insurers directly cover the cost of care. Therefore, patients' access to the service remains limited. However many patients are eligible for reimbursement after sustaining the out-of-pocket expense, and payment schedules are considered on an as-needed basis.

To learn more about JeffTIP call (215) 955-STOP, or by searching "Tobacco" on Jefferson's Web site:
<http://www.jeffersonhealth.org>

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Currently, the Comprehensive Center for Tobacco Research and Treatment is undertaking a number of research studies that examine the basic inheritable risk for nicotine dependence. Research to date on the subject suggests that inheritable "hard-wiring" plays an important role in determining a person's risk for developing dependency behaviors. One Center study that has received national attention attempts to shed light on the genetic determinants of severe nicotine dependence by identifying the genetic loci responsible for this effect. As the lead organization in this multi-center trial, Jefferson's investigators will be responsible for recruiting 400 pairs of siblings into the study over the next two years. Research examining the relationship between twin sibling smoking status and their environment suggests that such an inheritable factor may indeed influence risk for tobacco use.

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NEW PUBLICATIONS FROM THE OFFICE OF HEALTH POLICY

Kalman B, Li S, Chatterjee D, O'Connor J, Voehl MR, Brown MD, Alder H. Large scale screening of the mitochondrial DNA reveals no pathogenic mutations but a haplotype associated with multiple sclerosis in Caucasians. *Acta Neurol Scand*. 1999;99:16-25.

Nash DB. Disease management programs: where do we go from here? *Drug Benefit Trends*. 1999;11(5):68-71.

Risk Contracting and Capitation Management: A Colloquy. Dove HG, Calabrese D, Gosfield AG, Miele MS, Nash DB, Thygeson NM (eds). Totowa, NJ: Emron, Inc., June 1999.

Rosenthal G. Making the case for quality: an interview with David Nash. *The Joint Commission Journal on Quality Improvement*. 1999;25(5):259-264.

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COMING SOON

Connecting with the New Healthcare Consumer: Defining Your Strategy. Nash DB, Manfredi MP, Howell SL, Bozarth BL (eds). Burr Ridge, IL: McGraw-Hill Healthcare Education Group. Publication: October 1999.

...A multiauthored book on the new "consumerism" in healthcare, designed for healthcare providers and professionals across the spectrum who want to gain a better understanding of the impact of this unprecedented revolution on the healthcare industry; and of their consumer markets, toward optimizing strategies that bind consumers and those who serve them more closely together.

Jefferson Medical College
Office of Continuing Medical Education
Selected Activities

September 24, 1999

Jefferson HealthCare College: Approaching the Patient with Vascular Disease: A Primer for Primary Care Physicians

Bluemle Life Sciences Building

Philadelphia, PA

Course Directors: *Geno J. Merli, MD, John Spandorfer, MD and Howard Weitz, MD*

No further information at this time.

October 8-10, 1999

The 8th Annual Symposium by the Sea

Rehoboth Beach Country Club

Rehoboth Beach, Delaware

Course Directors: *James Beebe, Jr., MD and Kenneth R. Epstein, MD, FACP*

Credit Hours: *Maximum of 12 hours*

Who should attend...*Physicians, particularly generalists interested in updates in aspects of Pain Management, Parkinson's Disease, Lyme Disease, Rheumatoid Arthritis, Hepatitis C, and Stroke/TIA's.*

Sponsored by: *Jefferson Medical College of Thomas Jefferson University and Beebe Medical Center*

October 9, 1999

The 3rd Annual Jefferson Headache Symposium

Bluemle Life Sciences Building

Philadelphia, PA

No further information at this time.

October 10-15, 1999

The Original 1999 Philadelphia Board Review Course in Cardiovascular Diseases

Wyndham Franklin Plaza Hotel

Philadelphia, PA

Course Director: *Arnold J. Greenspon, MD*

Credit Hours: *Maximum of 50 hours*

Who should attend...*Cardiovascular Fellows or Cardiovascular Physicians in Practice who wish an intensive, thorough review before the Boards, or other medical personnel who wish to update their knowledge in cardiology.*

Sponsored by: *Jefferson Medical College of Thomas Jefferson University*

Co-Sponsored by: *The Council on Clinical Cardiology of the American Heart Association*

October 18-22, 1999

8th Annual High Risk & Critical Care Obstetrics Course

Philadelphia, PA

Course Directors: *Nan H. Troiano, RN, MSN,*

Ronald J. Wapner, MD, and Stuart Weiner, MD

Credit Hours: *Maximum of 28.75 hours*

Who should attend...*Physicians, Subspecialty Fellows and Nurses.*

Sponsored by: *The Office of Continuing Medical Education of Jefferson Medical College and The Department of Obstetrics & Gynecology, Division of Maternal-Fetal Medicine.*

October 28, 1999

Urology Update

Philadelphia, PA

No further information at this time.

November 12, 1999

Jefferson HealthCare College: Prevention in the Year 2000

Course Directors: *Randa Sifri, MD, Michael Steinberg, MD and Richard C. Wender, MD*

No further information at this time.

December 10, 1999

Jefferson HealthCare College: Diagnostic Dilemmas: Choosing the Best Test

Course Directors: *Geno J. Merli, MD, Robert Perkel, MD and Richard C. Wender, MD*

No further information at this time.

More Information

Various Dates

1999 Ultrasound Education Programs

Philadelphia, PA

Course Director: *Barry B. Goldberg, MD*

Sponsored by: *Division of Diagnostic Ultrasound, Department of Radiology of Thomas Jefferson University and Jefferson Medical College*

For more information on these courses, please call 215-955-8533 or Fax 215-923-9452.

Jefferson Medical College of Thomas Jefferson University, as a member of the Consortium for Academic Continuing Medical Education, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

For more information, call the Office of CME at 215-955-6992 or 1-888-JEFF-CME (533-3263).

PHYSICIAN-FOCUSED WEB SITE CLASSIFICATION SCHEME

LISA E. MCCARTNEY, BS, ASSISTANT PROJECT DIRECTOR, OFFICE OF HEALTH POLICY, JMC

SANUJ RAVINDRAN, MD, JMC CLASS OF '98*

The retrieval and dissemination of information to modern physicians has been revolutionized by the World Wide Web (WWW). Veteran health-care organizations and innovative health information companies use the WWW to offer medical information and services in a comprehensive, condensed and facile package. Particularly attractive to physicians, these applications can increase the cost effectiveness of medical practices by summarizing the burgeoning health-care advancements to make knowledge processing and application more efficient. The Office of Health Policy at Thomas Jefferson University developed a physician-focused Web site classification scheme to (1) determine the Web sites that are most comprehensive and relevant to physicians; (2) establish a comparison across Web site packages to allow the physician to evaluate the best package for their needs; (3) familiarize individuals with the scope of medical information available via the WWW; and, (4) provide physicians with criteria that can be used to rate new and revised Web site packages. By reviewing the literature and assessing different physician behavior patterns, several criteria were selected to measure the value of a Web site package. The table below details the four Web sites that most completely met all of the criteria (also listed). However, with the rapidly changing WWW, Web site packages will be born, merge and die. This physician-focused Web site classification scheme provides physicians with criteria that can be used to evaluate these packages into the future.

Comprehensive Health Portals Itemized by Selection Criteria

Portals		Medcast**	Medscape	WebMD	Physicians' Online
Mode of Connection	Hardware Needed	Computer w/ Internet Access	Computer w/ Internet Access	Computer w/ Internet Access	Computer w/ Internet Access
	Software Available	w/ fee	Web-based	Web-based	Web-based
	Included in Fee	Additional Fee	No	Additional Fee	Additional Fee
	Membership Fee	\$10.00/ month	\$29.95/ month	\$29.99/ month	Free
	Secure e-mail Account	Yes	Yes	Yes	Yes
Continuing Medical Education	CME On-Line?	Yes	Yes	Yes	Yes
	Access to Associations and Specialty Organizations	Yes	Yes	Yes	Yes
Practice Management Tools	Guidelines & Pathways	Yes	Yes	Yes	Yes
	Employment & Recruiting	No	Yes	Yes	Yes
	Referral Services	No	Yes	Yes	No
	On-Line Insurance Verification	No	Yes	Yes	No
	Personal Organizer	No	Yes	Yes	No
	Create Your Own Web Site	No	Yes	Yes	Yes
	Dictation and Transcription Services	No	Yes	Optional	No
Clinical Management Tools	Links to Medical Databases	Yes	Yes	Yes	Yes
	Access to On-Line Textbooks	No	Yes	Yes	Yes
	Links to Peer-reviewed Journals	Yes	Yes	Yes	Yes
	On-Line Purchasing of Books and Medical Supplies	Yes	Yes	Yes	Yes
	Personal Financial Management Tools	Yes	Yes	Yes	Yes
Customization Capabilities	Specialty-specific Information Available	Yes	No	Yes	Yes
	Information Further Customized for Individual Needs	Yes	No	No	No
Patient Resources	Disease-specific Information	Yes	No	Yes	No
	Patient Support Resources	Yes	Yes	Yes	Yes
Medical News	Peer-reviewed Journal Articles	No	No	Yes	No
	Medical News Headlines	Yes	Yes	Yes	Yes
Social Information	Current Events	Yes	Yes	Yes	Yes
	Travel	Yes	Yes	Yes	Yes
	Lifestyle	Yes	Yes	Yes	Yes

* Second year resident in internal medicine, Strong Memorial Hospital, U. of Rochester Medical Center, Rochester, NY.

** Medcast services available through WebMD; merger pending as of press time.

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